dissecting aneurysm and extravasation of blood into the circumjacent tissues, resulting in a fatal mediastinal hemorrhage and left hemothorax.

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THE INTENTIONAL SIMULATION OF PERINEPHRITIC ABSCESS AND ACUTE APPENDICITIS

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THE following instance is unique in the use of knowledge to simulate perinephritic abscess and acute appendicitis. A third-year student nurse, aged twenty-four years, gave a history of having scratched her left arm while pinning on the cuff of her uniform, the scratch occurring in an old scar resulting from radium treatment of a birthmark. The scratch was at such a location that the sleeve and cuff of the uniform continually rubbed it while the patient was at work.

REPORT OF CASE

Patient was admitted to the hospital on March 3, 1930, at which time the arm was red, indurated, and hot. The temperature was 101, pulse 88, respiration 20. Leukocytes were 15,500, of which 90 per cent were polymorphonuclears. The urine showed a trace of albumin. On March 8, tenderness and swelling developed in the left flank. Heat and redness were also present. A perinephritic abscess was suspected, secondary to the infection in the arm. This swelling gradually subsided and had practically disappeared on March 16.

On March 18, the patient complained of severe pain in the right lower quadrant of the abdomen. The temperature at this time was 104; the leukocyte count, 25,500, of which 92 per cent were polymorphonuclears. There was marked tenderness over McBurney's point and very definite spasm of the right rectus muscle. Nausea was present and the patient vomited on several occasions. Rectal examination gave negative information. A surgical consultant made a diagnosis of acute appendicitis and advised operation. At operation an incision made through the right rectus muscle demonstrated a marked edema in the subcutaneous tissues. There was no pus. Exploration of the abdomen was entirely negative. A normal appendix was removed. An inflammatory reaction developed about the wound. Probing of the wound on subsequent days revealed no pus. On April 3, approximately two weeks after operation, probing resulted in the discharge of a large quantity of greenish-yellow foul pus. Culture revealed a hemolytic streptococcus, beta type, and a gamma streptococcus. Following drainage, the wound healed, and the patient was discharged on April 16.

After her discharge from the hospital it was learned from this patient that both the perinephritic abscess and the appendicitis were simulated by her. Dreading a temporary service in another hospital, required of all student nurses, she took saliva from her own mouth and injected it with a Luer syringe and a long needle into the left lumbar region. When it became evident to her that this condition was being handled satisfactorily and she was beginning to recover from it, she injected saliva into the right rectus muscle over McBurney's point.

In her confession she stated that she feared someone might observe the needle-puncture wound in the skin in either instance. Later, after the onset of pain and tenderness in the right lower abdomen, she was fearful that the needle had penetrated the peritoneum and that an acute peritonitis was developing. Even when beset with these fears, it did not occur to her to acquaint anyone with what had happened.

The likeness of the clinical picture to appendicitis as recorded above was very striking.

Following psycho-analytical care, this patient was judged to have a constitutional psychopathic personality.

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AN IMPROVED CERVICAL BRACE

By STEPHEN T. RAGAN, M. D.
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THE hazard of automobile traffic, the frequency of aeroplane crashes, the showmanship in wrestling matches, and the spectacular in football contests, have greatly increased the incidence of cervical fractures during the last decade. Many of these patients die early from accompanying cord damage, but a great number sustain fractures of the body, the processes, the laminae, or the pedicles, without showing evidence of paralysis below the area of trauma. After preliminary hospitalization, during which period a suitable brace is fitted, such patients do well upon ambulatory treatment.

In the manufacture of our cervical brace, a plaster cast of the cervical and upper dorsal region is made. This extends from the lower lip anteriorly, and the mastoids posteriorly, down the torso to the eighth rib. From this model, plates of twenty gauge duralumin are made to fit the chin, occiput, chest, and shoulders. Metal tubing is extended downward from each side of the chin and occiput plates, to slip over three-sixteenth-inch spring alumin rods, extending upward from the chest and shoulder plates. The rods are threaded, and carry lock nuts for height adjustment. Contact sides are padded with quarter-inch felt, covered with light horse hide, and an outside trim of light sole leather is sewed in place. One-half-inch straps and buckles connect chin to occipital plate, and breast to shoulder plate. At the inferior border of the apparatus, a one-inch webbed strap encircles the thorax to prevent slipping. The total weight is twenty-nine ounces.

Because of fit and easy adjustment, absolute immobility is assured. Ventilation is adequate.

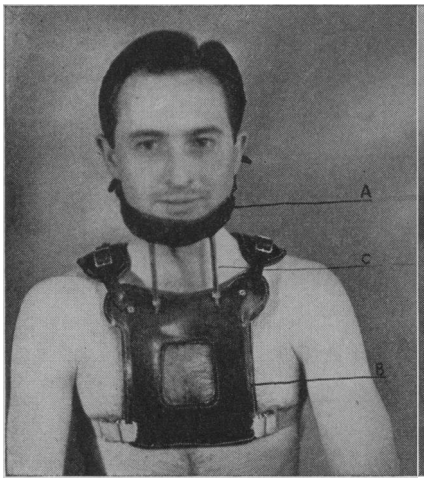

Fig. 1

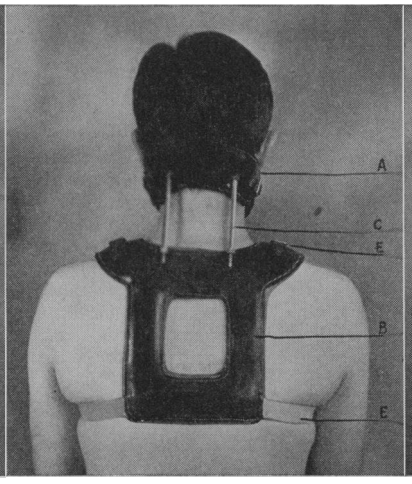

Fig. 2

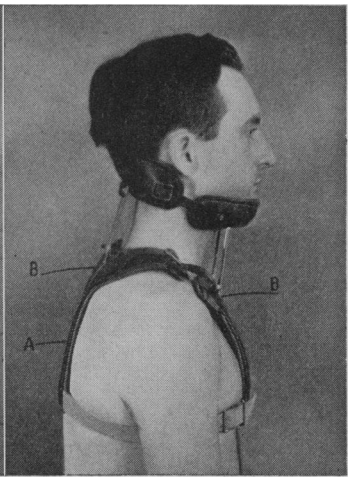

Fig. 3

Fig. 1.—Front view. The chin piece (a) connects with ventilated chest plate (b) by adjustable rods.

Fig. 2.—Rear view. The occiput piece (a) connects with the ventilated shoulder plate (b) by adjustable rods (c). Straps and buckles (e) hold the apparatus in place.

Fig. 3.—Side view. (a) The weight of the apparatus does not rest upon muscle borders or upon important nerves. (b) Either half is removable for convenience in bathing, shaving or hair-cutting.

The weight of the apparatus and sustained anatomical parts rest comfortably upon the broad surfaces of the pectorals and trapezii, and not upon the thin superior borders of these muscles, nor upon the clavicles. There are no pressure points, and discomfort about the cervical plexus is minimized. A strip of gauze may be placed in the chin and occipital recesses, and this is changed frequently to insure cleanliness. Either half of the brace may be removed for convenience in shaving, hair cutting, or bathing.

Pain in any of the nerve units making up the cervical or brachial plexus may be a distressing early symptom, but this is usually transient in character. A persistence would indicate a compression of nerve root by bony fragments, and a gradual increase in intensity would suggest the impingement of a nerve root by callus.*

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CIRCUMCISION OF YOUNG CHILDREN

By EDWIN F. PATTON, M. D.
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A QUESTION about which there is a confusing variety of opinion is: To circumcise or not to circumcise a growing boy. The situation involves both medical and surgical considerations, but the answer is easy. Individual cases fall into three categories: (*a*) urgent, (*b*) desirable, and (*c*) unnecessary.

Criteria cataloguing a case as urgent are:

Phimosis making retraction difficult and favoring adhesions and retention of smegma.

Paraphimosis, of any degree.

Recurrent or persistent balanitis.

Redundancy of prepuce to the extent of hiding the meatus, retaining the last drop of urine, and keeping preputial tube or meatus macerated or irritated.

Circumcision is desirable when the case presents:

Tendency to recurrence of adhesions of prepuce to corona, in spite of one or more forcible retractions and stretchings.

Redundancy interfering with cleansing, but not with retraction.

Circumcision is unnecessary when:

With penis lying normally, meatus is exposed, clearing prepuce by a quarter inch or more in all directions.

Retraction and cleansing are free and easy.

Circumcision of girls can be summed up in one statement: It is never justifiable, except in case of rare congenital abnormality. Even forcible preputial retraction in girls is never justifiable, unless the adhesions are so dense that they can be broken up only by instrumentation. At the right time, accelerated secretion of smegma ordinarily accomplishes this separation, and common efforts of cleanliness maintain it.

Results of circumcision, aside from relief of local irritation, facilitation of erection, improvement of access for cleanliness, and cosmetic appearance, are practically nil. Promises that enuresis, masturbation or "handling" will cease after circumcision cannot be made with real assurance. When circumcision is done, the object should be to convert a case in Class A or B into one possessing the characteristics described under Class C, namely, exposed meatus and free retractibility.

The time to circumcise is as young as possible. The younger the patient the less the scarring, and the more favorable the course and result. Babies up to three months of age can be operated upon without anesthesia; anesthesia between three and six months is optional; after the age of six months anesthesia is required.

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* The cervical brace here described is made by M. J. Benjamin, 514 Paramount Theatre Building, to whom I am indebted for assistance in mechanical details.